MOTHERCARE II MIDTERM EVALUATION

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by

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The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

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ACKNOWLEDGEMENTS

The MotherCare II midterm evaluation team is deeply indebted to many individuals whose efforts to provide us with background information, access to ongoing project activities, and logistics support made our assignment possible. The team would like to thank the many officers of USAID and MotherCare in Washington, D.C., Indonesia, and Bolivia who made themselves available for interviews. We would also like to thank the staff of POPTECH for its excellent preparation of our assignment, logistics support, and editorial assistance.

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The team is especially appreciative of the work of the USAID COTR for MotherCare, Mary Ellen Stanton, and her staff for the preparation of a very thorough evaluation Scope of Work (see Appendix A). The Scope of Work's review of the project background and elaboration of questions to be addressed by the evaluation team contributed a great deal to the organization of our work and our report.

The team is also grateful for the cooperation we received from the dozens of informants listed in Appendix C whose generous sharing of time and views toward MotherCare allowed us to appreciate how MotherCare is valued by the international development community for advancing reproductive health reform.

This midterm evaluation of MotherCare II (HRN-5966-C-00-3038-00 and HRN-5966-Q-00-3039-00) was conducted for the Office of Health and Nutrition of the Population, Health and Nutrition Center of the Global Bureau of USAID. The Population Technical Assistance Project (POPTECH) of BHM, International, Inc. conducted the evaluation.

ABBREVIATIONS

ACNM	American College of Nurse-Midwives
ADB	Asian Development Bank
BASICS	Basic Support for Institutionalizing Child Survival
BKKBN	Indonesian National Family Planning Coordinating Board
BLSS	Basic Life Saving Skills
CA	Cooperating Agency
CARE	Cooperative for Assistance and Relief Everywhere
CDC	Centers for Disease Control and Prevention
CD-ROM	compact disc - read only memory
CEDPA	Centre for Development and Population Activities
COTR	Contracting Officer's Technical Representative
CPTAFE	association combatting FGM in Guinea
DHS	Demographic and Health Surveys
DO	Delivery Order
EPB	Expanded Promotion of Breastfeeding
FGM	female genital mutilation
FHI	Family Health International
FS	Field Support system
HKI	Helen Keller International
IBI	Indonesian Midwives Association
IBRD	International Bank for Reconstruction and Development (World Bank)
ICPD	International Conference on Population and Development (United Nations; Cairo)
ICRW	International Center for Research on Women
IEC	information, education, and communication
IJGO	*International Journal of Gynecology and Obstetrics*
IMR	infant mortality rate
IPAS	International Projects Assistance Services
IPC	interpersonal communication
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JSI	John Snow, Inc.
KAP	knowledge, attitudes, and practices
LOE	level of effort
LSHTM	London School of Hygiene and Tropical Medicine
MCH	maternal and child health
MMR	maternal mortality ratio
MOH	Ministry of Health
MOU	memorandum of understanding

MVA	manual vacuum aspiration
NCIH	National Council for International Health
NGO	nongovernmental organization
Ob/Gyn	obstetrician/gynecologist physician
ODC	other direct costs
OMNI	Opportunities for Micronutrient Interventions Project
OR	operations research
PAHO	Pan American Health Organization
PATH	Program for Appropriate Technology in Health
PHN	population, health, and nutrition
PHR	Partnerships for Health Reform Project
PKK	The First Lady's association in Indonesia
POLICY	Population Analysis, Planning and Action Project
POPTECH	Population Technical Assistance Project
PVO	private voluntary organization
RFA	request for applications
RH	reproductive health
RTI	reproductive tract infection
SEATS	Family Planning Services Expansion and Technical Support Project
SO2	Strategic Objective 2
SOW	Scope of Work
STD	sexually transmitted disease
STI	sexually transmitted infection
TA	technical assistance
TAG	Technical Advisory Group
TBA	traditional birth attendant
UNICEF	United Nations Childrens Fund
USAID	United States Agency for International Development
USAID/W	USAID/Washington
WACH	Women and Children Health Project (India)
WHO	World Health Organization

PROJECT IDENTIFICATION DATA

Project Title:	MotherCare II Subproject
Country:	Global
Contract:	HRN-5966-C-00-3038-00/HRN-5966-Q-00-3039-00
Contract Dates:	
Start Date:	September 29, 1993
End Date:	September 29, 1998
Contract Funding:	$20,986,840; no ceiling on requirements contract (Q)
Obligations to Date:	
Core (C):	US$17,341,281
Requirements (Q):	US$11,673,738
Mode of Implementation:	Contract between the Office of Health and Nutrition, the Global Bureau, and John Snow, Inc.
Contractor:	John Snow, Inc. 210 Lincoln St. Boston, MA 02111
Responsible USAID Officials:	
Contracting Officer:	Michael B. Gushue (at time of evaluation, 9-10/96) Sharon Zavestoski (as of 11/18/96)
COTR:	Mary Ellen Stanton
Previous Evaluation:	None

EXECUTIVE SUMMARY

Over the last eight years, the United States Agency for International Development's (USAID) initiative to improve maternal and neonatal health and nutrition has made a significant contribution towards achieving the Population, Health and Nutrition (PHN) Center's *Strategic Objective 2 (SO2)*: *Increased use of safe pregnancy, women's nutrition, family planning, and other key reproductive health interventions*. In 1988, USAID's Bureau of Science and Technology (now the Global Bureau) developed the Maternal and Neonatal Health Project. Under that project authorization, a five-year contract (1988-1993) was awarded to John Snow, Inc. (JSI) to implement the first subproject (MotherCare I) committed to improving maternal and neonatal health and nutrition. MotherCare II is the second phase of that subproject with a five-year contract (1993-1998).

A detailed description of the background, objectives, strategies, and activities of MotherCare I and II appear in chapter 3 and Appendix A (evaluation Scope of Work [SOW]).

Purpose

The purpose of this evaluation is to help MotherCare II successfully accomplish its task of

> "assisting country health care systems and private sector programs, to deliver selective and appropriate interventions for the care of women of reproductive age and their newborn infants, especially maternity services, as a means of reducing maternal and neonatal malnutrition, morbidity, and mortality."

This entails assessing MotherCare's performance and progress to date, and advising on any needed redirection of strategies or priorities during the remainder of the project.

Additionally, this evaluation will help to chart the future of reproductive health programs in the PHN Center. The evaluation document will be a critical resource for the follow-on senior consultation which will bring together "visionaries" and practitioners in the field of women's reproductive health and nutrition to discuss what is known and what must still be learned to operationalize client-centered, high-quality, cost-effective, sustainable reproductive health services and create an enabling environment for behavior change. This senior consultation is anticipated for spring, 1997.

Methodology

The MotherCare II Project was evaluated by a three? member team composed of Dr. Albert Henn (team leader), Dr. Claudia Morrissey, and Dr. Bebe Jo Selwyn. This midterm evaluation

occurred in September and October of 1996, three years through the five-year life of the project (1993-1998). The evaluation team reviewed extensive documentation from both MotherCare I and MotherCare II and had 15 days of direct contact with interested individuals, institutions, and with MotherCare's activities in Washington, D.C., Indonesia, and Bolivia.

Overall Impression

The team was fortunate to be able to begin its work by attending the 1996 MotherCare Technical Advisory Group (TAG) meeting in Washington. The meeting convened participants from USAID, MotherCare headquarters, MotherCare field offices, and from numerous collaborating governments, international agencies, nongovernmental organizations (NGOs) and other collaborating agencies to review MotherCare's experience.

From the warm collegial and professional atmosphere which prevailed at the TAG meeting, and from the interviews and site visits conducted in Washington and overseas, the evaluation team was favorably impressed with the quality of MotherCare's work and the degree to which MotherCare has established itself as a highly respected and productive leader of institutions in the international development community working in reproductive health, particularly women's health and neonatal health. The team found that MotherCare had created tangible excitement about working together on something so important.

Accomplishments

MotherCare's principal accomplishments during the period being evaluated include:

- Analyzing the rich experience of MotherCare I and disseminating its findings and recommendations to the international reproductive health community;
- Broadening the focus of reproductive health to include the integrated services needed to address the continuum of women's health needs from before pregnancy, through pregnancy and delivery, to include neonatal care;
- Providing leadership and maintaining a remarkable atmosphere of mutual respect, commitment, and support among many local and international organizations and professionals working for reproductive health development;
- Leading in the development of several diagnostic tools and their application in formative research that informs program design and implementation;
- Identifying priority research needs to advance the state of the art and supporting selected

studies to determine the effectiveness of specific interventions; and

? Introducing numerous locally innovative implementation efforts to increase the quality of reproductive health services delivery.

Results

MotherCare II is working hard in its long-term countries to obtain by the end of the project demonstrable results in improved health status, increased utilization of services, and improved quality of service delivery. Already it has realized a number of related interim results including the following:

? The design and piloting of diagnostic tools (situation analysis, training needs assessment, community diagnosis, and baseline survey);

? The execution and analysis of validation studies to determine the reliability of self-reporting of obstetric complications;

? The engagement of Muslim religious leaders in Indonesia in discussions aimed at establishing religious policies promoting reproductive health objectives;

? The adoption of agreed-upon norms and standards for reproductive health practices in Bolivia and in South Kalimantan, Indonesia;

? The development of competency-based training curricula based on these norms and standards and the initiation of training programs in Bolivia and Indonesia;

? The adoption of a policy in a Russian state, promoting early exclusive breastfeeding and "rooming in";

? The establishment of Safe Motherhood as a central theme for the 1996 Bolivia meeting of First Ladies of the Western Hemisphere; and

? The establishment of formal avenues of coordination and collaboration with the World Health Organization (WHO) and the World Bank for the continued development of diagnostic tools, practice norms and standards, training curricula, and policy reform guidelines.

As MotherCare II is active in seven "long-term countries" and has provided short-term technical assistance to over 15 additional developing countries, the above listing of interim results is illustrative as opposed to comprehensive. The complete list of results will continue to grow as

MotherCare works toward its long-term objectives of reducing maternal and neonatal morbidity and mortality.

LIST OF RECOMMENDATIONS

Concerns to be Addressed by the Contracting Officer's Technical Representative (COTR) or MotherCare

Most of the recommendations made by the evaluation team relate to concerns which are specific to the MotherCare Project and which we believe should be addressed by the COTR or MotherCare.

For the COTR

? So much time has been required for pre-implementation activities in the long-term emphasis countries that the time remaining in the MotherCare contract is insufficient to allow enough implementation time to permit impact evaluation, thorough analysis of the experiences, wide dissemination of lessons learned, and effective advocacy for policy reform. **The evaluation team recommends that the COTR work with the project and with USAID to secure MotherCare II a costed contract extension which will permit the project to carry out the full range of activities expected of it until the end of the umbrella project in September 2000.** (Recommendation #1 and #29, pgs. 19 and 32)

? There is some uncertainty regarding how long MotherCare II will be operational and how best to use the remaining time and resources to accomplish as much as possible on behalf of the PHN Center's *SO2*. **The COTR should work with USAID to determine the amount of time to be approved for the project and the corresponding definition of achievements to be realized in that time. The COTR should also work with MotherCare to develop a strategy and work plan for the remainder of the project to ensure that the project meets all its objectives.** (Recommendation #3 and #30, pgs. 20 and 32)

? MotherCare staff (technical and support/administrative) all appear to be very hardworking and productive, yet there is more demand for MotherCare analyses, technical assistance and other services than existing staff can provide. The most apparent needs for additional technical staff capacity are in the areas of advocacy and dissemination, research oversight, and in the Indonesia office. **The COTR should work with the project to encourage rapid recruitment to fill all approved positions and with USAID to authorize additional staff as needed, including an information, education, and communication (IEC) specialist and a nurse midwife for MotherCare's Indonesia office.** (Recommendation #4, #11, and #32, pgs. 20, 24, and 33)

For MotherCare

- Although MotherCare has earned a leadership role in the international development community working in reproductive health, its approach to advocacy and dissemination has not yet been well defined. **MotherCare should make advocacy and dissemination one of its highest priorities for the remainder of the project. MotherCare II should develop a clear advocacy and dissemination strategy and work plan for the remainder of the project, and ensure that this priority activity is adequately staffed to meet its objectives.** (Recommendation #14, p. 26)

- MotherCare's current dissemination activities are almost limited to the distribution of *MotherCare Matters* and the publication of rare peer-reviewed journal articles. **MotherCare should concentrate its dissemination efforts on peer-reviewed publications and take advantage of WHO's offer to use its distribution network whenever possible.** (Recommendation #16, p. 27)

- There is an expressed need on the part of several USAID/Washington (USAID/W) officers for more frequent briefings from MotherCare. **MotherCare should prepare a clearly articulated vision statement and schedule regular meetings with USAID stakeholders to brief them on the evolving MotherCare approach, work in progress, key issues, and expectations for the future.** (Recommendation #5 and #18, pgs. 21 and 28)

- The locally hired professionals in MotherCare's overseas offices have expressed a desire for in-service training in planning, management, and research methodology. **MotherCare should provide its overseas professionals with in-service training because this would be a direct investment in the local sustainability of MotherCare's contributions to reproductive health.** (Recommendation #19, p. 28)

- Although MotherCare recognizes gender bias as an important determinant of reproductive health and has undertaken several initiatives aimed at empowering women, the project has not yet formulated a clear strategy for addressing this issue. **In the initial stages of its program planning and implementation process, MotherCare needs to articulate a clear strategy for combating gender bias within the context of reproductive health and incorporate into the strategy the intention to work closely with women's groups at the community level.** (Recommendation #21, p. 28)

- Adolescents are increasingly recognized as a group with special unmet reproductive health needs. **MotherCare should continue its efforts to increase the understanding of the special reproductive health needs of adolescents and to develop effective programs that respond to those needs.** (Recommendation #22, p. 29)

? MotherCare? supported field research appears to need closer oversight to ensure that it continues to adhere to the high-quality research standards MotherCare has established as its trademark. **MotherCare should take steps to ensure that the field research projects it supports are undertaken by professionals who are well trained in research methodology and are regularly supervised by headquarters' staff.** (Recommendation #12, p. 25)

? MotherCare's field staff have expressed a need for better understanding of qualitative research methodology and of the processes for applying the results of the diagnostic studies to reproductive health program planning. **MotherCare should develop and disseminate manuals to its field staff for each diagnostic tool. The manuals should present guidelines for qualitative research methodology, including analysis techniques, and for the application of study findings to program design and policy reform.** (Recommendation #13, p. 26)

? The impact of MotherCare's training programs in its long-term countries is essentially limited by the number of in-country participants. **MotherCare should explore the feasibility of using distance learning techniques such as correspondence, radio, and computer-based training to reach a widely dispersed target population of health workers in developing countries.** (Recommendation #10, p. 23)

? Although MotherCare is active in its efforts to stimulate policy reform, it is not taking a systematic approach to this aspect of its work. **MotherCare should explore whether adopting a more systematic approach, such as those employed by USAID's Population Analysis, Planning and Action (POLICY) project and Partnerships for Health Reform (PHR) project, would make it more effective in promoting policy reform.** (Recommendation #15, p. 26)

? MotherCare, like other projects, is having difficulty finding reliable indicators for measuring the impact of interventions which have been in place for only one or two years. **MotherCare should continue its efforts to study the validity of alternative indicators for evaluating the impact of reproductive health interventions.** (Recommendation #9, p. 23)

? The MotherCare TAG expressed a concern that it is not contributing sufficiently to MotherCare's work. **MotherCare should explore ways to further involve the TAG, perhaps through giving it more structured responsibility during TAG meetings and giving the TAG members selected assignments between meetings.** (Recommendation #28, p. 31)

? Some USAID/W officials have declared that their schedules sometimes do not permit them to read as many of MotherCare's reports as they would like. **MotherCare should**

consider attaching a one-page summary to all but its shortest reports. (Recommendation #17, p. 27)

? Although African women are at the highest risk of maternal mortality, no African countries are represented among MotherCare's long-term countries. **MotherCare should continue its efforts to understand the determinants of reproductive health in Africa and consider renewing its efforts to locate an appropriate long-term country in Africa if the MotherCare II project is sufficiently extended.** (Recommendation #6, p. 22)

Broader Issues to be Addressed by USAID

In addition to the more project-specific concerns cited above, the evaluation team also identified a number of broader issues which are essentially outside of MotherCare's control but which might be addressed by USAID to allow the project to function more effectively in the short term and/or to render USAID's future programs more effective in the long term.

To be Addressed for MotherCare's Benefit as Well as Future Projects

? Due to the difficulties inherent in the available mechanisms for transferring Mission funds to the project, there have been occasions when Missions have been unable to access technical assistance from MotherCare. These problems have usually been due to either the difficulty of getting Delivery Orders (DOs) approved and processed in a timely fashion or the inability of MotherCare to accept further funding through the Field Support (FS) system without leaving so little remaining under its authorized core contract ceiling that its headquarters' financing would be jeopardized. **USAID should explore ways of alleviating this procedural barrier so that Missions can avail themselves of MotherCare's services (e.g., streamlining the DO process or raising the core contract ceiling to allow for more FS transfers).** (Recommendation #31, p. 33)

? It has not yet been decided by USAID whether the state of the art in reproductive health is sufficiently advanced to warrant the development of a "flagship" project to serve the PHN Center's *SO2*: Increased use of safe pregnancy, women's nutrition, family planning, and other key reproductive health interventions. Such a "flagship" project would be capable of simultaneously carrying out the research necessary to continue advancing the state of the art, conducting worldwide dissemination and advocacy activities, and supporting reproductive health program development and implementation based upon existing technology. **MotherCare has clearly demonstrated that the state of the art in reproductive health has passed the threshold level of development at which support of a "flagship" project becomes warranted. We recommend that USAID modify the MotherCare Project and/or design a follow-on project to ensure that *SO2* receives the level of support a "flagship" project can provide.** (Recommendation #2, p. 19)

? There seems to be considerable impatience at the Mission level with the amount of time MotherCare II has required to establish effective partnerships with national governments, conduct and analyze its diagnostic studies, and plan its interventions before undertaking actual program implementation. **Engaging national governments as partners, conducting and analyzing formative research, and applying research findings to collaborative intervention planning are all key elements of implementation. USAID should work with its Missions to help their officers appreciate the essential nature of each of these steps in the development process.** (Recommendation #8, p. 22)

For the Benefit of Future USAID Programming

? It appears that the designers of the MotherCare II project expected that the project would be able to begin implementation of field programs more rapidly since it was essentially just "going to scale" with what had been demonstrated to be effective at the district level in MotherCare I. **The evaluation team observed that "going to scale" for MotherCare was not simply an increase in the quantity of activities to be supported, but it also required a time-consuming change in the quality of activities to be undertaken as new partnerships had to be forged, new populations understood, and new service delivery systems analyzed. USAID should consider extending the normal length of large applied research projects to seven to ten years.** (Recommendation #7, p. 22)

? USAID's increasing tendency to encourage the utilization of local professionals to staff field project offices has definite implications for the sustainability of its development assistance. **USAID should promote regular in-service training of local contractor professional staff because their continued career development will help to sustain the successes of their programs.** (Recommendation #20, p. 28)

? USAID's results orientation under re-engineering appears to emphasize short-term interventions like in-service training and discourage interventions which make an impact over the longer-term such as preservice training, even though in the long run the latter may be less expensive and more sustainable. **USAID should commit to the improvement of preservice training with the objective of eventually limiting in-service training to the upgrading of skills rather than continuing to rely on it to impart basic skills.** (Recommendation #23, p. 29)

? USAID-supported projects in any sector can gain experience which could benefit other projects. There is a need to improve sharing of experience across sectors. **USAID should continue its efforts to increase the sharing of projects' lessons learned, such as MotherCare's experience working directly with the newly empowered municipalities in the Bolivian model of decentralized government.** (Recommendation #24, p. 29)

? There appears to be an internal inconsistency when USAID carefully matches resources provided to projects with results required, yet expresses its frustration when projects are unable to be flexible and seize local opportunities. **USAID should endow its projects with a fixed percentage of discretionary funds if the projects are expected to have the flexibility to seize unanticipated local opportunities.** (Recommendation #25, p. 29)

? At the same time that USAID is promoting increased collaboration between cooperating agencies (CAs), it creates barriers to the CAs' ability to work together by supporting fewer CAs per developing country and by expecting CAs to demonstrate the impact of their work which might require them to work in locations where other CA's activities will not be a confounding factor in impact evaluation. **USAID should explore ways to encourage collaboration between CAs, taking into account Missions' desires to limit the number of CAs working in a country and USAID's expectation that CAs demonstrate the impact of their work.** (Recommendation #26, p. 30)

? Development work is characterized by unpredictable changes in political, economic, and other uncontrollable factors that affect the outcome of project initiatives, yet projects are often criticized when such factors result in diminished productivity and/or the failure to meet original objectives. **USAID should attempt to articulate what kinds of circumstances it considers outside a contractor's control and provide guidance to contractors regarding how to adjust to such circumstances in ways that help preserve original objectives.** (Recommendation #27, p. 30)

Conclusion

Two remarkable comments heard from local reproductive health professionals in the field characterize the overall conclusion of the evaluation team:

> **"In reproductive health, MotherCare means quality."**

and

> **"MotherCare must be protected because there is still so much to learn about reproductive health...."**

1. INTRODUCTION

The MotherCare II Project was evaluated by a three-member team composed of Dr. Albert Henn (team leader), Dr. Claudia Morrissey, and Dr. Bebe Jo Selwyn. This midterm evaluation occurred in September and October of 1996, three years through the five-year life of the project (1993-1998). The evaluation team reviewed extensive documentation from both MotherCare I and MotherCare II and had 15 days of direct contact with interested individuals and institutions and with MotherCare's activities in Washington, D.C., Indonesia, and Bolivia.

The purpose of the evaluation is to help MotherCare II successfully accomplish its task of

> "assisting country health care systems and private sector programs to deliver selective and appropriate interventions for the care of women of reproductive age and their newborn infants, especially maternity services, as a means of reducing maternal and neonatal malnutrition, morbidity, and mortality."

This entails assessing MotherCare's performance and progress to date and advising on any needed redirection of strategies or priorities during the remainder of the project. Additionally, this evaluation is intended to help chart the future of reproductive health programs supported by USAID. Toward these ends, this evaluation document is prepared as a resource for the follow-on senior consultation that will bring together "visionaries" and practitioners in the field of women's reproductive health and nutrition to discuss what is known and what must still be learned to operationalize client-centered, high-quality, cost-effective, sustainable reproductive health services and create an enabling environment for behavior change. The workshop is planned for spring 1997, and will address both how to make the most of the remaining time of the MotherCare II Project and how USAID can most effectively continue its efforts to serve the PHN Center's *SO2*.

2. METHODOLOGY

The midterm evaluation of the MotherCare II Project was undertaken through USAID's POPTECH project which assembled the evaluation team and provided the team with the evaluation SOW, background documents, logistics, and editing support.

The evaluation was conducted from September 17-October 18, 1996. The evaluation team's work began with a review of available documents and attendance at the TAG meeting on September 18-20. In addition to the technical advisors for the project, the TAG meeting brought together the field directors, selected field staff, and key Ministry of Health (MOH) personnel from each of the long-term country programs: Indonesia, Bolivia, and Guatemala.

The focus of the TAG meeting was to review the progress of program components and to discuss the pros and cons of the diagnostic instruments that have been developed and field tested during MotherCare II. The diagnostic instruments include the baseline survey, community diagnosis, situation analysis, training needs assessment, and validation protocol. Data were shared from two of MotherCare's long-term countries? Bolivia and Indonesia? where the instruments have recently been administered. These results, plus program implementation updates, led to a rich discussion of lessons/strategies for further programming of integrated reproductive health services and helped identify strengths and weaknesses of the project as it enters the last half of its contract period. This discussion by technical experts and program implementors provided valuable information for the midterm evaluation team.

After attending the TAG meeting, the team attended the MotherCare Research Meeting on September 23. This was followed by interviews of USAID staff (Global/Regional), MotherCare field/central staff, and other stakeholders. Conference calls were conducted with PHN offices in the USAID Missions where MotherCare is working. Sixteen days were spent conducting field visits to two of the long-term countries, Indonesia and Bolivia. The remaining time was spent working on the draft evaluation report and preparing for the debriefing held on October 17.

Hundreds of documents were reviewed, two long-term intensive country programs were visited, and over 100 informants were interviewed for the evaluation. The names of the principal informants and their contact information is presented in Appendix C.

3. BACKGROUND

3.1 Significance of Problem and Relationship to USAID/PHN Strategic Objectives

Each year over half a million women in developing countries lose their lives giving birth. The major causes of maternal mortality (hemorrhage, sepsis, obstructed labor, eclampsia, and the sequelae of unsafe abortion) are preventable with known technologies. Millions more women suffer direct and long-term complications of pregnancy and delivery. Larger still are the numbers of women who live with the discomfort and dangers of reproductive tract infections (RTI) (and the potential for increased transmissibility of the HIV virus) and suffer from micronutrient deficiencies and protein/calorie undernutrition. Two million girls are at risk each year for female genital mutilation (FGM) and its associated medical complications. In addition, many women do not yet have access to methods for spacing or avoiding further pregnancies.

The health of women also has a profound impact on the health of newborns. On average, more than half of infant deaths in developing countries occur during the neonatal period. Many of these deaths result from complications of labor and delivery or from low birth weight due, in part, to maternal undernutrition or infection. When childbirth results in death of the mother, the infant's chances of surviving the first year of life are extremely poor. As might be expected, most interventions designed to improve maternal health and nutrition have also improved infant health and nutrition.

Over the last eight years, USAID's initiative to improve maternal and neonatal health and nutrition has made a significant contribution toward achieving the PHN Center's *SO2*: *increased use of safe pregnancy, women's nutrition, family planning, and other key reproductive health interventions*. In 1988, USAID's Bureau for Science and Technology (now the Global Bureau) developed the Maternal and Neonatal Health Project. Under that project authorization, a five-year contract (1988-1993) was awarded to John Snow, Inc., (JSI) to implement the first subproject (MotherCare I) committed to improving maternal and neonatal health and nutrition. Two other subprojects were awarded: Wellstart International's Expanded Promotion of Breastfeeding Program (EPB) and a WHO grant.

In 1991, the title of the umbrella project was changed to the Breastfeeding and Maternal and Neonatal Health Project, and the life of the project was initially extended until 1998 and subsequently until 2000. The project life for MotherCare I was September 1988-September 1993 and for MotherCare II is September 1993-September 1998.

3.2 MotherCare I: Purpose and Accomplishments

The purpose of MotherCare I, as stated in the USAID Logical Framework (1988), was

> "To demonstrate the feasibility of providing a package of effective, appropriate maternal and neonatal care services and education to women and their infants in selected developing settings."

The specific program objectives were to reduce maternal and neonatal mortality and morbidity and to promote the health of women and newborns.

Due to the paucity of scientific documentation of experience addressing these problems throughout the developing world at that time, a program was initiated through a phased approach beginning with small demonstration projects (population level 100,000-500,000) in the first five years, with the intention of scaling up to comprehensive regional or national efforts in the second five years.

MotherCare I was able to implement the following (see *MotherCare 1989-1993: Country Project Descriptions* for details):

- Demonstration projects in five countries: Indonesia, Uganda, Nigeria, Guatemala, and Bolivia. Long-term projects were also initiated in Bolivia and Bangladesh through the Save the Children Federation.

- Technical assistance to 11 countries with an emphasis on assessing the maternal health status or the prevalence of breastfeeding. Technical assistance to 14 countries responding to requests to develop plans or assist in implementing interventions aimed at reducing maternal and neonatal mortality and related morbidities. MotherCare I emphasized training birth attendants and educating women and families in clean and safe delivery.

- Competitive, Peer-reviewed Research Projects:

    * In Ecuador, a clinical trial of the efficacy of the Kangaroo Mother Method;

    * In Indonesia, a study of the effectiveness of reducing anemia through a village-based distribution of iron folate tablets by traditional birth attendants (TBAs), with and without an IEC campaign;

    * In Indonesia, a study of the effectiveness of and compliance with a new "gastric delivery system" iron supplement;

    * In Indonesia, a clinical trial of the efficacy of Clindamycin cream in preventing

premature births caused by bacterial vaginosis among pregnant women; and

* In Kenya, an assessment of the effectiveness of integrating single-visit syphilis screening and treatment into prenatal clinic services to prevent congenital syphilis.

3.3 Lessons Learned from MotherCare I

The wide variety of demonstration activities supported by the MotherCare I Project resulted in many lessons learned which should be valuable in the implementation of MotherCare II. Among the most important are the following:

? Maternal complications and maternal mortality are closely associated with perinatal mortality and long-term negative health consequences for the infant. Improving the nutritional status of the mother, both before and during pregnancy, has an important positive impact on pregnancy outcomes;

? Traditional birth attendant training alone, without establishing links to higher referral levels for essential obstetric care, does not significantly reduce maternal mortality. TBA training, therefore, should emphasize recognition of the need for referral and should take into account the availability and accessibility of higher level medical facilities for emergencies;

? The delegation of life-saving obstetric functions to midwives and nurses at the first referral level is critical to reducing maternal mortality in most developing countries. This issue should, therefore, be pursued at the policy level;

? Improvements in public health and socioeconomic indicators do not reduce maternal mortality unless accompanied by improved access to quality services such as skilled obstetric care, antibiotics, and blood transfusions. Nevertheless, broader women's health issues do interact with pregnancy outcomes? women's nutritional status prior to pregnancy has an impact on the birth weight of their infants, FGM may lead to delivery complications, and many sexually transmitted diseases (STDs) are implicated in stillbirths and neonatal morbidities;

? Demographic risk as a definition of high-risk pregnancies overwhelms health service capabilities in limited-resource settings because it does not have high sensitivity for detecting those truly at risk or specificity for reducing the number of women classified as high risk. Instead, referral should be based on early identification and case management of actual obstetric complications;

? MotherCare I's comparative advantage has been primarily in advocacy for safe

motherhood, training and IEC; and

? While the outcomes of research/demonstration projects are of great value in their own right, it is important to scale up effective interventions to a regional or national level. This increases the impact on reducing maternal and neonatal morbidity, mortality, and malnutrition, elevates program needs to the national policy agenda, and benefits more women and infants.

3.4 Focus of MotherCare II

MotherCare II has the dual objectives of applying the lessons learned from MotherCare I's small-scale demonstration activities to programs at the regional or national level and continuing further research to address remaining knowledge gaps.

In addition, MotherCare II has a broader mandate than MotherCare I. This includes addressing additional key women's health issues (anemia control and treatment; RTI and STD prevention, diagnosis and treatment; postabortion care; female genital mutilation; and family planning promotion) in an integrated package of reproductive health services. In addition, MotherCare II is expected to move beyond a pregnancy-focused approach to a "reproductive-age woman" approach and extend outreach and services beyond public health systems by involving private practitioners, nongovernmental organizations (NGOs), and private voluntary organizations (PVOs). Avenues to involve communities that were found promising in MotherCare I, such as working through women's groups, are to be utilized more extensively.

3.5 Contractual Requirements of MotherCare II

The contract identified the following tasks for MotherCare II:

3.5.1 Long-term Country Programs

Up to seven countries will be chosen for comprehensive, long-term (longer than one year) programs. Countries in different regions and at different points on the spectrum of socioeconomic and health system development will be selected. Up to five of the long-term countries will feature "to scale," comprehensive, regional, or national programs, while two will be smaller demonstration projects. Approximately four countries will be designated as intensive, with a country advisor in residence.

A Long-term Country Work Plan will be developed for each country and will be the basis for project activities. One component of the Long-Term Country Work Plan will be the preparation

of a baseline checklist detailing the required characteristics of a regional or national comprehensive maternal and neonatal health and nutrition program against which progress may be assessed. The work plans will be reviewed at least annually and outputs measured against specified goals and benchmarks.

Comprehensive programs are expected to exhibit the following characteristics and will be evaluated accordingly:

- A national policy for improving maternal and neonatal health and nutrition;
- A national committee or other coordinating body formed to oversee maternal and neonatal health and nutrition planning and high-level Ministry staff with strong advocacy roles designated to be responsible for these activities;
- A national budget with adequate allocation of resources to support activities in maternal and neonatal health and nutrition;
- National targets for improving maternal and neonatal health and nutrition with a national system for monitoring and evaluating progress towards achieving these targets;
- Norms and standards of obstetric treatment at each referral level of the health care system and staff trained in these protocols;
- Maternal and neonatal health and nutrition programs designed to have the greatest impact on health services;
- National programs with at least the following components: IEC; training to include preservice and refresher training for health care providers, especially midwives and traditional birth attendants; accessible, high-quality maternity care services; adequate salary support; and a system for insuring the supply and delivery of essential drugs, supplies, and equipment;
- A Long-term Country Work Plan.

3.5.2 Short-term Technical Assistance

Short-term (three months or less) technical assistance will take place in as many developing countries as possible, in response to requests from Missions, MOHs, PVOs, NGOs, and other donors.

3.5.3 Competitive, Peer-reviewed Applied Research

MotherCare II will conduct further in-depth analyses. MotherCare II will also publish results of service coverage and pregnancy outcome data collected in demonstration activities during MotherCare I and findings of new applied research. The results will be widely disseminated through publications, especially peer-reviewed journals, and conferences.

A research plan will be completed by the end of year one. New applied research studies will be supported on topics that show promise for improving women's health and nutritional status and pregnancy outcomes for both mother and newborn. The results should be generalizable and applicable to many countries and thus there will be a preference for multi-country studies on the same topic. Peer review of research activities will be provided by the TAG.

3.5.4 Worldwide Policy-related Activities

Some illustrative activities include production of publications; organization and participation in workshops and seminars; attendance at professional meetings; and dialogue with governments, interest groups, and communities. Policy activities worldwide will be undertaken with the goal of delegating authority from obstetricians to midwives, where appropriate; providing a lobby for women's health concerns in general; and, specifically, drawing attention to the need to address acute and chronic maternal and neonatal health and nutrition needs.

3.5.5 Information Dissemination

During MotherCare II, the Working Papers Series begun by MotherCare I will continue, but the focus of the information dissemination will shift to peer-reviewed journal articles and should total at least 20 published articles. *MotherCare Matters*, a newsletter developed for education and advocacy on state-of-the-art approaches to maternal and neonatal health and nutrition, will continue and should increase circulation from 2,000 to 3,500 copies.

3.6 MotherCare II Current Activities

The tasks outlined in the contract have been undertaken in collaboration with five major subcontractors: The American College of Nurse-Midwives (ACNM); the Program for Appropriate Technology in Health (PATH); Family Health International (FHI); the London School of Hygiene and Tropical Medicine (LSHTM); and the Academy for Educational Development (AED). This section presents current MotherCare II activities implemented or ongoing in various countries. The evaluation team reviewed these activities to determine the progress the project has made toward completing the tasks outlined in the contract.

3.6.1 Long-term Country Programs - Intensive Countries

Indonesia. MotherCare II is working with the Indonesian Midwives Association (IBI) to provide training on basic and advanced lifesaving skills to facility and village-based midwives. Assistance is also provided to IBI to increase its capacity to influence reproductive health and safe motherhood programs on a national level. In South Kalimantan, MotherCare works with the MOH to provide comprehensive reproductive health services to women. These services include improving treatment of infections and anemia (increasing supplies and compliance with iron folate supplementation) during antenatal care; incorporating family planning into postpartum care; and strengthening the skills of *Bidan di desas* (Indonesian traditional birth attendant) as well as *bidans* (Indonesian nurse-midwives) to attend women during labor and delivery.

Bolivia. MotherCare II is working to develop an integrated reproductive health program with the MOH in the five districts of El Alto (population 1 million) and Cochabamba (population 407,800). Training for health providers, nurse auxiliaries, nurses, and doctors is under way in antenatal care, including syphilis screening and treatment; anemia reduction and prevention; obstetric/newborn (normal/complicated) management; and postpartum/postabortion care, including family planning. IEC is being developed to target pregnant women and their families to improve knowledge and use of these reproductive health services. A hospital-based syphilis study will determine the level of syphilis among women delivering in hospitals. MotherCare is also providing technical support for community-based reproductive health strategies by working with NGOs and PVOs through PROCOSI, an umbrella agency.

Guatemala. MotherCare is training TBAs, doctors, and nurses to identify and respond quickly to obstetric and newborn complications in four areas (Solola, San Marcas, Totonicapan, and Quetzaltenango? population 527,524). Anemia prevention and treatment is incorporated into antenatal care. Various service delivery protocols have been developed for this care, and IEC will focus on increasing service demand.

Egypt. Project development is under way.

3.6.2 Long-term Country Programs - Less-Intensive Countries

India. MotherCare is working with NGOs under the Private Voluntary

Organizations for Health II Project (PVOH II) to conduct workshops on state-of-the-art issues in reproductive health and in qualitative research on STDs. MotherCare is also working with four NGOs on programs to address issues related to anemia (its prevalence, etiology, and perceptions of women and providers regarding anemia and iron folate tablets) and evaluate interventions implemented to address these issues.

Honduras. MotherCare is providing technical support to the MOH by undertaking a situational analysis at a sample of facilities in nine health areas in Honduras. This analysis includes an inventory of equipment and an assessment of the quality of care provided for maternal and neonatal health and nutrition services. Service delivery protocols for hospital personnel for the management of obstetric complications are being developed. Formative research on anemia is in process, and planning for a neonatal study and intervention is under way.

Pakistan. MotherCare is participating in the Pakistan NGO Initiative (PNI) with the Basic Support for Institutionalizing Child Survival (BASICS) project and Wellstart International's EPB to provide technical assistance to expand/develop the capacity of local NGOs in reproductive health programming. Although MotherCare does maintain a long-term advisor in Islamabad, Pakistan is "less-intensive" because the PNI approach of fostering a civil society does not readily present an opportunity to program for population, health, and nutrition projects.

3.6.3 Technical Assistance

Guinea. MotherCare performed a maternal/infant health assessment and developed the maternal and child health (MCH) strategy for the USAID Mission. In addition, MotherCare is currently working with the Program for Appropriate Technology in Health (PATH) and a local NGO to develop an FGM eradication intervention, based upon on-going qualitative and quantitative research.

Honduras. MotherCare participated in a three-day strategy meeting to assist in the development of a national strategy to strengthen maternal and infant health.

Malawi. MotherCare is working through a subcontract with Project Hope and the London School of Hygiene and Tropical Medicine, to coordinate operations research activities focusing on the prevalence, causes and risk factors for anemia in specific program areas.

Peru. MotherCare provided technical assistance to the Instituto de Investigacion Nutricional (IIN) as part of the MotherCare-funded study "Improving Iron Intake

in Adolescents and Women of Fertile Age to Prevent Iron Deficiency Anemia." In addition, MotherCare II has provided technical assistance to ReproSalud, an NGO umbrella agency, to replicate the community-based process initiated by women's groups in rural Bolivia under Save the Children (auto diagnosis), to diagnose and address problems of safe motherhood and family planning promotion.

Russia. MotherCare participated in the Russian/American Reproductive Health Seminar in St. Petersburg, May-June 1995. MotherCare also collaborated with the Family Planning Services and Technical Support (SEATS) project to improve maternal and neonatal health services provided in two areas in Russia by introducing training on a family-centered maternity care approach with specific focus on exclusive breastfeeding/lactational amenorrhea method (LAM) and STDs.

Uganda. MotherCare provided technical assistance for the evaluation of the MotherCare I Ugandan Life Saving Skills project.

Ukraine. MotherCare participated in a series of reproductive health seminars in Odessa, Donetsk, and Lviv. After carrying out an assessment of maternity care, MotherCare incorporated training on a family-centered maternity approach into a training package for the Refresher Training Institutes in Donetsk.

Yemen. MotherCare prepared a complete maternal and neonatal health assessment and made recommendations to the USAID Mission for prioritizing these issues and planning possible interventions.

Zambia. MotherCare performed an assessment with the Cooperative for Assistance and Relief Everywhere (CARE)/Zambia which provided a basis for working to improve the health and nutritional status and contraceptive acceptance rate of adolescent girls.

3.6.4 Applied Research - Diagnostic Studies

MotherCare II has developed prototype diagnostic research tools and methodologies for reproductive health including: validation studies; community diagnosis; situation analysis; training needs assessment; and baseline survey.

3.6.5 Applied Research - Competitive, Peer-reviewed

Thailand. MotherCare II has conducted research to determine the cost/effectiveness of and client satisfaction with a streamlined approach to prenatal care versus traditional care.

Ghana. MotherCare II is testing the feasibility and safety of a training program for non-physician providers of postabortion care at the community level.

Indonesia. MotherCare II has evaluated the impact of low-dose vitamin A on maternal and neonatal sepsis.

Peru. MotherCare II has measured the impact of supplementation and dietary approaches to reduce anemia in adolescents and women of reproductive age.

Uganda. MotherCare II measured the effect of mass STD treatment on maternal morbidity and perinatal mortality and morbidity; and conducted a qualitative study of knowledge, attitudes, and practices (KAP) and sexual and health care seeking practices and perceptions among young adults in regards to STDs.

3.6.6 Worldwide Policy-related Activities

International Meetings. MotherCare disseminated research findings through presentations at a variety of international meetings: National Council for International Health (NCIH), American Public Health Association (APHA), United Nations International Conference on Population and Development (ICPD), the Pan American Health Organization (PAHO) TAG meeting, IAG on Safe Motherhood, Donor Workshop on Implementing Reproductive Health Programs, U.N. Fourth World Conference on Women, and the Pediatric Conference in Cairo, Egypt (for complete listing see Appendix D).

Indicator Development. MotherCare led subcommittees on safe pregnancy/women's nutrition indicators as part of the EVALUATION Project's efforts to develop indicators for reproductive health.

Collaboration with Other Organizations.

- MotherCare collaborated with the World Bank, United Nations Childrens Fund (UNICEF), United Nations Population Fund (UNFPA), WHO and other international organizations on developing indicators and presenting findings of program and research data.

- MotherCare worked with the Pan American Health Organization (PAHO) to develop a maternal mortality surveillance system and joint maternal syphilis prevention and treatment activities.

3.6.7 Dissemination Activities

Publications. MotherCare expanded the circulation of *MotherCare Matters* to over 2,800 and has produced a number of additional publications (see Appendix D).

4. OBSERVATIONS AND CONCLUSIONS

The evaluation team was guided in its efforts by the nearly 100 detailed questions provided in the evaluation SOW. The team found these questions to be comprehensive but too repetitive for use in the body of this report. For readers who are interested in how the evaluation team addressed each of these questions, both the questions and our detailed responses are presented in Appendix B. Appendix B contains a wealth of detail which could not be included within the limited space of the body of the report. It should be reviewed by those actively involved in the continuing operation of MotherCare II.

This section of the report focuses on the major issues which emerged during the evaluation and the evaluation team's recommendations for the future of both MotherCare and USAID's treatment of reproductive health. This section presents the team's observations and conclusions relating to three areas: 1) the overall technical performance of the project, 2) the five principal task assignments of the project, and 3) the administration of the project.

4.1 MotherCare II's Overall Technical Performance

During its brief exposure to the MotherCare II Project (attending the TAG meeting and the research review meeting; interviewing collaborating agencies, subcontractors, USAID officials, MotherCare staff, and developing country government officials; and reviewing project documentation and visiting project field sites in Indonesia and Bolivia) the evaluation team was very impressed by the quality of MotherCare's technical work and the leadership role that the project has earned in the international development community working with reproductive health. MotherCare's applied research is advancing the state of the art in reproductive health; its advocacy and dissemination efforts are sharing these advances globally; and it is helping selected long-term countries implement reproductive health programs based on the existing state of the art.

This midterm evaluation team for the MotherCare II Project has reviewed the project's performance with respect to what was mandated by the contract, as amended, and within the context of the administrative, political, and field conditions which it operates. Despite its time constraints, the evaluation team looked at a wide range of issues, from the "macro" to the "micro." Most of the micro management issues are related to the details of local project implementation and have been communicated directly to MotherCare headquarters. The rest of our observations and the ensuing recommendations are reflected in this report.

The strongest single impression held by the evaluation team after its study is that in the MotherCare Project, USAID has established a particularly effective leader in the campaign to reduce maternal and neonatal mortality through the development of client-centered, high-quality, integrated, cost-effective, and sustainable reproductive health services. This remarkable

achievement is the result of the synthesis of a broad spectrum of contributing factors including: the availability of appropriate technology, adequate funding, USAID's commitment, supportive management, and outstanding MotherCare staff. Each of these factors is essential, but the high quality and commitment of MotherCare's staff is clearly what sets MotherCare apart as a leader in the field of reproductive health.

The evaluation team found that MotherCare II is making definite progress toward all of the goals, objectives, and outputs specified in the contract. The number of countries in which long-term, intensive, going "to scale" activities are supported is now three (Indonesia, Bolivia, and Guatemala) and is being expanded to include Egypt and, possibly, India. Honduras and Pakistan both benefit from a less-intensive level of long-term support. At least a dozen additional countries have received short-term technical assistance from MotherCare and special applied research projects are being supported in another five countries. MotherCare II is definitely affecting policy through its active collaboration with other donors such as the World Bank and the World Health Organization, its sponsorship of meetings, its rigorous analysis and sharing of the MotherCare I experience, and its many publications. MotherCare has already produced over half of the peer-reviewed articles mandated, and its major effort to publish is expected to increase with the close-out analysis of the MotherCare II experience.

While the evaluation team is very impressed with the progress of the MotherCare II Project and its value to the international reproductive health community, the project has experienced significant constraints. These will affect the degree to which this progress can be maintained and the ability of the project to realize the full potential of USAID's investment by the scheduled end of the project in September 1998. So much time was required to start up the long-term, intensive country programs that, in most cases, the actual implementation of the training and quality of care improvement activities designed on the basis of the diagnostic studies is only just beginning.

One such constraint is the fact that those who designed the MotherCare II Project underestimated the amount of time needed to agree upon target countries and establish the collegial, participatory relationships with local authorities needed to go "to scale" with MotherCare I demonstration activities. Instead of being a simple quantitative change, this required the establishment of entirely new relationships with government officials and the design and testing of qualitatively different approaches needed to implement programs on a regional or national scale. In retrospect, it would appear that MotherCare II has done an excellent job of going "to scale" in several countries while carrying on all of its other contract mandates. However, since this transition has required more time than anticipated, there is not enough time remaining for the program innovations to be in place in order to effectively measure and analyze their impact and share the results with the international community.

MotherCare II's present dual mandate is to continue the research begun under MotherCare I while expanding its focus beyond a pregnancy orientation to encompass both reproductive-age women's health and neonatal health; and to apply the lessons learned at regional or national levels. The evaluation team notes that much of MotherCare II's first three years have been consumed by the synthesis and dissemination of the MotherCare I experience; the engagement of national and regional government officials as active participants; and the design, testing, and application of the diagnostic tools (situation analysis, training needs assessment, community diagnosis, validation study and baseline study). Because of this the two years remaining will not be sufficient to allow MotherCare to implement the full range of training for quality of care improvement, awareness raising for demand generation, and promotion of increased community involvement for a adequate period of time to permit accurate measurement and evaluation of their respective impacts and dissemination of experience to the international reproductive health community.

We estimate that the program implementation phase of MotherCare should be in place for at least one year before its effectiveness can be assessed. At least one more year would be required for MotherCare to distill the lessons learned from the MotherCare II experience and appropriately disseminate the findings to advance the state of the art and develop an advocacy campaign to influence corresponding policy reform. Given that MotherCare II is only beginning program implementation in its long-term emphasis countries (Indonesia, Bolivia, and Guatemala) and is about to embark upon new programs in India and Egypt, we recommend that MotherCare II be extended beyond its planned termination in September 1998 for as long as can be allowed under the umbrella project (e.g., until September 2000).

Recommendation

1. **The evaluation team recommends that the COTR work with the project and with USAID to secure MotherCare II a costed contract extension which will permit the project to carry out the full range of activities expected of it until the end of the umbrella project in September 2000.**

Since this evaluation is also intended to provide background and recommendations to be utilized at the senior consultation to plan the detailed future of MotherCare II and to help shape future USAID programming for reproductive health, the following recommendations are intended to ensure that USAID realizes the greatest level of development benefit possible from its investment in MotherCare.

Recommendations

2. **MotherCare has clearly demonstrated that the state of the art in reproductive health has passed the threshold level of development at which**

support of a "flagship" project becomes warranted. We recommend that USAID modify the MotherCare Project and/or design a follow-on project to ensure that *SO2* receives the level of support a "flagship" project can provide.

3. **The COTR should work with USAID to determine the amount of time to be approved for the project and the corresponding definition of achievements to be realized in that time. The COTR should also work with MotherCare to develop a strategy and work plan for the remainder of the project to ensure that it meets all its objectives.**

4. **The COTR should work with the project to encourage rapid recruitment to fill all approved positions and with USAID to authorize additional staff as needed, including an IEC specialist and a nurse midwife for MotherCare's Indonesia office.**

MotherCare II is applying the lessons learned from MotherCare I (see Appendix B for a description of how each lesson learned cited in the final evaluation of MotherCare I is being applied). Its most significant accomplishments to date include:

- Analyzing the rich experience of MotherCare I and disseminating its findings and recommendations to the international reproductive health community;

- Broadening the focus of reproductive health to include the integrated services needed to address the continuum of health needs from before women become pregnant, through pregnancy and delivery, to include neonatal care;

- Providing leadership and maintaining a remarkable atmosphere of mutual respect, commitment, and support among many local and international organizations and professionals working for reproductive health development;

- Leading in the development of several diagnostic tools (situation analysis, training needs assessment, community diagnosis, and baseline survey) and their application in formative research which is used in program design and implementation;

- Identifying priority research needs to advance the state of the art and supporting selected studies to determine the effectiveness of specific interventions;

- Introducing numerous locally innovative implementation efforts to increase the quality of reproductive health services delivery;

- Executing and analyzing validation studies to determine the reliability of the self-reporting of obstetric complications;

- Engaging Muslim religious leaders in Indonesia in discussions aimed at establishing religious policies promoting the objectives of reproductive health;

- Adopting agreed upon norms and standards for reproductive health practices in Bolivia and in South Kalimantan, Indonesia;

- Developing competency-based training curricula based on these norms and standards and initiating training programs in Bolivia and Indonesia;

- Adopting a policy promoting early exclusive breastfeeding and "rooming in" in a Russian state;

- Establishing Safe Motherhood as a central theme for the 1996 Bolivia meeting of First Ladies of the Western Hemisphere; and

- Establishing formal avenues of coordination and collaboration with WHO and the World Bank for the continued development of diagnostic tools, practice norms and standards, training curricula, and policy reform guidelines.

Although the MotherCare II staff are clearly working well together toward a mutually understood common set of objectives, there was some expressed desire on the part of USAID officers for a better understanding of MotherCare's "vision" and its work in progress.

Recommendation

5. MotherCare should prepare a clearly articulated vision statement and schedule regular meetings with USAID stakeholders to brief them on the evolving MotherCare approach, work in progress, key issues, and expectations for the future.

4.2 MotherCare II's Five Principal Task Assignments

4.2.1 Long-term Country Programs

Although the MotherCare II contracts refer to "going to scale" in up to five emphasis countries, the difficulty of securing USAID/Washington (USAID/W), Mission, and host country agreements while USAID is engaged in re-engineering, and the length of time required for start-up activities, have combined to limit the number of intensive long-term MotherCare field

programs to three (Indonesia, Bolivia, and Guatemala). However, less-intensive long-term programs are also under way in Honduras and Pakistan, and programs in India and Egypt are under development. The evaluation team notes that in spite of its efforts, MotherCare has been unable to develop a long-term country program in Africa where individual women face the highest levels of maternal mortality. Because MotherCare has so effectively demonstrated that extensive formative and applied research are required to plan and implement locally effective quality of care improvement interventions, we recommend that USAID and MotherCare intensify the effort to ensure that the MotherCare approach is applied to the specific needs of African women.

Recommendation

6. MotherCare should continue its efforts to understand the determinants of reproductive health in Africa and consider renewing its efforts to locate an appropriate African long-term country if the MotherCare II project is sufficiently extended.

Since the MotherCare I field activities that were to serve as the models for "going to scale" were smaller, community level demonstration activities, often undertaken in collaboration with local NGOs, MotherCare has found that moving to comprehensive regional or national programs undertaken in collaboration with governments has required as much a qualitative change in approach as a quantitative one. Engaging ministries and national institutions and regional authorities as committed, active participants in applying MotherCare's approach to reproductive health development on a larger scale has taken a great deal of advocacy work and has accounted for much of the time required to start up MotherCare II's field activities. Again, although process outputs can be demonstrated, unless MotherCare II is extended, there will not be enough time for these delayed field activities to have measurable impacts.

Recommendation

7. The evaluation team observed that "going to scale" for MotherCare was not simply an increase in the quantity of activities to be supported, but it also required a time-consuming change in the quality of activities to be undertaken as new partnerships had to be forged, new populations understood and new service delivery systems analyzed. USAID should consider extending the normal length of large applied research projects to seven to ten years.

There seems to be considerable impatience at the Mission level with the amount of time MotherCare II has required to establish effective partnerships with national governments,

conduct and analyze its diagnostic studies, and plan its interventions before undertaking actual program implementation.

Recommendation

8. Engaging national governments as partners, conducting and analyzing formative research, and applying research findings to collaborative intervention planning are all key elements of implementation. USAID should work with its Missions to help their officers appreciate the essential nature of each of these steps in the development process.

The evaluation team found that MotherCare has become involved as an active participant in local policy deliberations and has established itself as a principal architect of reproductive health services development in each of the long-term program sites visited, Indonesia and Bolivia.

MotherCare is now initiating the implementation of reproductive health programs in its long-term countries and is establishing the data collection systems which will be used to evaluate the impact of its initiatives. Considerable attention is being given to the challenge of identifying impact indicators to reliably show change after only one or two years of program implementation.

Recommendation

9. MotherCare should continue its efforts to study the validity of alternative indicators for evaluating the impact of reproductive health interventions.

MotherCare emphasizes competency-based training in an effort to provide a more sustainable benefit to the trainees, but there are limits to the number of trainees that can be offered supervised hands-on practical training.

Recommendation

10. MotherCare should explore the feasibility of using distance learning techniques such as correspondence, radio, and computer-based training to reach a widely dispersed target population of health workers in developing countries.

4.2.2 Technical Assistance

Both collaborating governments and local USAID Missions have been uniformly impressed with the high quality of the long-term and short-term technical assistance provided by MotherCare; consultants have generally been well-briefed, available in a timely fashion, and qualified with local experience. It is also evident that MotherCare is working hard to ensure continuity through repeated use of the same short-term consultants and the hiring of highly qualified host country professionals as resident advisors.

The evaluation team was impressed to find that all MotherCare staff (technical and support/administrative) are very hardworking and productive. However, the demand for MotherCare analyses and technical assistance exceeds the level that existing staff can provide. The most apparent needs for additional technical staff capacity are in the areas of advocacy and dissemination, research oversight, and in the Indonesia office.

Recommendation

11. The COTR should work with the project to encourage rapid recruitment to fill all approved positions and with USAID to authorize additional staff as needed, including an IEC specialist and a nurse midwife for MotherCare's Indonesia office.

4.2.3 Applied Research

Internally, MotherCare has a clearly articulated set of research objectives. In the aggregate they are intended to answer questions such as the following:

- How can the quality of reproductive health services be improved most effectively and efficiently?
- How can we best increase both demand for and access to improved services?
- What are the best ways to monitor service delivery and the impact of reproductive health interventions?

An important part of the research MotherCare has undertaken is related to the design, testing, and application of the diagnostic tools. Their application in the field has not only provided the formative data needed to plan the upgrading of service facilities, training programs, and quality of care interventions needed in each setting, but has also demonstrated the importance of qualitative information for planning interventions to effect attitude and behavior change.

The diagnostic tools (community diagnosis, situation analysis, training needs assessment, auto-diagnosis [Warmi approach], and baseline study) have been used in a collaborative way with

government ministries at both national and district levels. This approach required more time than if MotherCare's researchers had proceeded alone, but MotherCare garnered the support and understanding of the usefulness of the various studies and promoted consensus on solutions to be implemented. The information gathered was used to plan IEC campaigns and to further develop training curricula to directly address issues identified in the diagnostic process. These tools are evolving based on the experiences MotherCare staff have had in applying them in local settings. The evaluation team recommends that MotherCare continue its efforts to develop a reduced and refined set of tools which will contribute greatly to the international community and to local countries.

The baseline survey is meant to form the first part of the comparative evaluation of the MotherCare program. There is debate, however, about its utility for assessing indicators that have to do with self-reported complications. It seems best suited for measuring knowledge and attitude changes and less for assessing prevalence. Another issue of concern is the enormous sample size used in some of the baseline surveys (>6,000 interviews). There is some question about the real need for this size of a sample. MotherCare will be carefully evaluating its own experience with the baseline surveys in order to decide whether a post-survey is useful, and if so, which aspects are the most useful in measuring impact. The goal is to acquire as much information in the most valid and efficient manner as possible.

At the 1996 TAG meeting it was clear that MotherCare's seminal work in the development of these diagnostic tools is helping to shape a common approach to such studies among members of the international reproductive health community. Among the most notable examples of respectful sharing stimulated by MotherCare was the decision for all institutions present at the meeting to accept WHO's Situation Analysis as a standard and to contribute to its continued refinement. Another such example was the decision to abandon efforts to use self-reporting of obstetric complications as a reliable indicator. This also underlined the importance of MotherCare's willingness to share its negative field trial results as well as reporting on its successes.

In addition to the broader formative and operations research associated with its long-term country programs, MotherCare has carefully identified focused research priorities related to ensuring safer deliveries and better birth outcomes by reducing pregnancy complications, improving women's nutrition, and combatting sexually transmitted infection. Using a competitive research proposal process, MotherCare has selected six special studies in these priority areas to receive technical and financial support. These studies are ongoing.

MotherCare-supported field research appears to need closer oversight to ensure that it continues to adhere to the high-quality research standards MotherCare has established as its trademark.

Recommendation

12. MotherCare should take steps to ensure that the field research projects it supports are undertaken by professionals who are well trained in research methodology and are regularly supervised by headquarters' staff.

MotherCare's field staff have expressed a need for better understanding of qualitative research methodology and of the processes for applying the results of the diagnostic studies to reproductive health program planning.

Recommendation

13. MotherCare should develop and disseminate manuals to its field staff for each diagnostic tool. The manuals should present guidelines for qualitative research methodology, including analysis techniques, and for the application of study findings to program design and policy reform.

4.2.4 Policy Reform

While MotherCare's approach to policy reform might benefit from the adoption of a systematic approach to assessing and influencing policies (such as have been developed by USAID's policy reform activities like the POLICY project and PHR activities), MotherCare is clearly succeeding in its efforts to stimulate reproductive health policy reform at both the international and national levels. To this end MotherCare is participating in international meetings, disseminating its findings through publications and other documentation, and working with national governments to develop and establish national norms and standards for service delivery facilities and practices for obstetric care and integrated antenatal, postpartum, and neonatal services.

As its formative and applied research contributes to advances in the state of the art for reproductive health, MotherCare actively disseminates its findings and recommendations through presentations at meetings and publications in a continuing effort to effect policy reform on an international scale. As the end of MotherCare II approaches, at least a year should be devoted to intensive dissemination of the lessons learned from its analyses and field activities.

Although MotherCare has earned a leadership role in the international development community working in reproductive health, its approach to advocacy and dissemination has not yet been well defined.

Recommendation

14. MotherCare should make advocacy and dissemination one of its highest priorities for the remainder of the project. MotherCare II should develop a

clear advocacy and dissemination strategy and work plan for the remainder of the project, and ensure that this priority activity is adequately staffed to meet its objectives.

15. MotherCare should explore whether adopting a more systematic approach, such as those employed by USAID's POLICY and PHR projects, would make it more effective in promoting policy reform.

4.2.5 Dissemination

In MotherCare I it was discovered that the dissemination of lessons learned takes a great deal of professional time. It fell to MotherCare II to invest much of its initial two years in sharing the MotherCare I experience with the international reproductive health community. That this was done effectively through a variety of publications and presentations is reflected in the high esteem MotherCare enjoys today. However, the evaluation team believes that the dissemination of lessons learned and advocacy for improved reproductive health care services delivery are too important to be left to a possible follow-on activity; they should be planned to be completed during the life of MotherCare II.

As previously suggested, MotherCare II should be sufficiently extended to permit carefully monitored implementation of its quality of care improvement initiatives for at least a year before they are evaluated and then another year for intensive analysis, dissemination, and advocacy activities. As MotherCare II approaches its end, its advocacy and dissemination activities should be made a top priority.

MotherCare's current dissemination activities are almost limited to the distribution of *MotherCare Matters* and the publication of rare peer-reviewed journal articles.

Recommendation

16. MotherCare should concentrate its dissemination efforts on peer-reviewed publications and take advantage of WHO's offer to use its distribution network whenever possible.

Some USAID/W officials said that their schedules do not always permit them to read as much of MotherCare's reports as they would like.

Recommendation

17. MotherCare should consider attaching a one? page summary to all but its

shortest reports.

4.2.6 Crosscutting Concerns

While there is definitely evidence of productive collaboration with other USAID-supported CAs at both the international and national levels, there is clearly room for improvement. This appears to be at least partially due to the need for a better understanding by USAID officials in Washington and in the Missions of what MotherCare is doing. Nearly everyone in USAID interviewed by the evaluation team expressed the desire for more regular presentations of MotherCare's vision, work in progress, accomplishments, and expectations for the future. The heavy research and implementation demands placed upon the small central staff and the small country staffs of MotherCare, combined with an understandable reluctance to promote interventions before their effectiveness has been adequately proven under field conditions, may have interfered with the frequency of MotherCare's briefing of USAID.

Recommendation

18. MotherCare should prepare a clearly articulated vision statement and schedule regular meetings with USAID stakeholders to brief them on the evolving MotherCare approach, work in progress, key issues, and expectations for the future.

The locally hired professionals in MotherCare's overseas offices have expressed a desire for in-service training in planning, management, and research methodology.

Recommendation

19. MotherCare should provide its overseas professionals with in-service training because this would be a direct investment in the local sustainability of MotherCare's contributions to reproductive health.

USAID's increasing tendency to encourage the utilization of local professionals to staff field project offices has definite implications for the sustainability of its development assistance.

Recommendation

20. USAID should promote regular in-service training of local contractor professional staff because their continued career development will help to sustain the successes of their programs.

Although MotherCare recognizes gender bias as an important determinant of reproductive health and has undertaken several initiatives aimed at empowering women, the project has not yet formulated a clear strategy for addressing this issue.

Recommendation

21. In the initial stages of its program planning and implementation process, MotherCare needs to articulate a clear strategy for combating gender bias within the context of reproductive health and incorporate into this strategy the intention to work closely with women's groups at the community level.

Adolescents are increasingly recognized as a group with special unmet reproductive health needs.

Recommendation

22. MotherCare should continue its efforts to increase the understanding of the special reproductive health needs of adolescents and to develop effective programs that respond to those needs.

USAID's results orientation under re-engineering appears to emphasize short-term interventions like in-service training and discourage interventions which make an impact over the longer-term such as preservice training, even though in the long run the latter may be less expensive and more sustainable.

Recommendation

23. USAID should commit to the improvement of preservice training with the objective of eventually limiting in-service training to the upgrading of skills rather than continuing to rely on it to impart basic skills.

USAID-supported projects in any sector can gain experience which could benefit other projects. There is a need to improve sharing of experience across sectors.

Recommendation

24. USAID should continue its efforts to increase the sharing of projects' lessons learned such as MotherCare's experience working directly with the newly empowered municipalities in the Bolivian model of decentralized

government.

There appears to be an internal inconsistency when USAID carefully matches resources provided to projects with results required, yet expresses its frustration when projects are unable to be flexible and seize local opportunities.

Recommendation

25. USAID should endow its projects with a fixed percentage of discretionary funds if the projects are expected to have the flexibility to seize unanticipated local opportunities.

At the same time that USAID is promoting increased collaboration between CAs, it creates barriers to the CAs' ability to work together by supporting fewer CAs per developing country and by expecting CAs to demonstrate the impact of their work which might require them to work in locations where other CA's activities will not be a confounding factor in impact evaluation. (For further discussion on this issue, see Appendix B, p. B-35, paragraph 2.)

Recommendation

26. USAID should explore ways to encourage collaboration between CAs, taking into account Missions' desires to limit the number of CAs working in a country and USAID's expectation that CAs demonstrate the impact of their work.

Development work is characterized by unpredictable changes in political, economic, and other uncontrollable factors that affect the outcome of project initiatives, yet projects are often criticized when such factors result in diminished productivity and/or failure to meet original objectives. MotherCare confronted one such obstacle when trying to select an African country as a long-term site. In several African countries Missions and MOHs have requested that fewer CAs work in their countries, consequently, CAs with existing activities have priority. (For further discussion on this issue, see Appendix B, p. B-13, paragraphs 4 and 5.)

Recommendation

27. USAID should attempt to articulate what kinds of circumstances it considers outside a contractor's control and provide guidance to contractors regarding how to adjust to such circumstances in ways that help preserve original objectives.

4.3 MotherCare II's Project Administration

4.3.1 Project Management

The evaluation team found that the management oversight of the MotherCare II Project has been characterized by the close professional relationship which exists between the USAID COTR, her staff and the MotherCare staff. The USAID project managers actively monitor the required deliverables and other management documentation. These appear to be in order and of high quality. USAID's technical project managers also participate actively as colleagues in MotherCare's ongoing development work.

We were very impressed with the internal management style and practices observed at MotherCare headquarters and at the two field offices. As reflected in the MotherCare organograms presented in Appendix G, there are clear lines of supervision and areas of responsibility which describe the relationships between both technical and support staff members. We were especially aware of the strong interpersonal relationships amongst the MotherCare staff. The warm, egalitarian, and thoroughly professional management style of MotherCare's leadership is certainly a major factor in the high level of staff productivity.

The relationships which exist between USAID/W, USAID Missions, JSI, its subcontractors, MotherCare headquarters and the MotherCare field offices appear to be uniformly productive. The staffing of long-term advisor and short-term consultant positions has employed a far-reaching selection process which has provided appropriate, high-quality expertise and often made use of in-country talent. There have been only a few exceptions to this high quality of staffing in the rare use of short-term advisors who don't speak Spanish in Latin America. These characteristics all contribute to MotherCare's position of respect in the international reproductive health community.

The MotherCare TAG expressed a concern that it is not contributing sufficiently to MotherCare's work.

Recommendation

28. MotherCare should explore ways to further involve the TAG, perhaps through giving it more structured responsibility during TAG meetings and giving the TAG members selected assignments between meetings.

4.3.2 Contractual Requirements

A review of the contracts shows that the stated deliverable requirements are being met at this

stage of the project. It is clear however that MotherCare will not be able to thoroughly implement and evaluate its quality of care improvement programs, and effectively share the lessons learned before the scheduled end of the project in September 1998.

Since pre-implementation activities in the long-term emphasis countries have required more time than anticipated, the time remaining in the MotherCare contract is insufficient for an adequate period of implementation which can be appropriately evaluated and thoroughly analyzed. In addition, there is not sufficient time for wide dissemination of lessons learned, and effective advocacy for policy reform.

Recommendation

29. The COTR should work with the project and with USAID to secure MotherCare II a costed contract extension which will permit the project to carry out the full range of activities expected of it until the end of the umbrella project in September 2000.

There is some uncertainty regarding how long MotherCare II will be operational and how to best use the remaining time and resources to accomplish as much as possible on behalf of the PHN Center's *SO2*.

Recommendation

30. The COTR should work with USAID to determine the amount of time to be approved for the project and the corresponding definition of achievements to be realized in that time. The COTR should also work with MotherCare to develop a strategy and work plan for the remainder of the project to ensure that the project meets all its objectives.

4.3.3 Finances and Level of Effort (LOE)

Current financial reporting appears to be in order and suggests that MotherCare II has sufficient funding to continue its present level of activities until its scheduled end in September 1998. Selected core accounts are underspent due to field activities which have been covered through Delivery Orders and other accounts are overspent due to the high level of demand for MotherCare's technical input. Line item transfers would appear to be adequate to support the project to September 1998 leaving a modest amount for inclusion in a possible extension budget.

The greatest financial problem faced by USAID and MotherCare appears to be the difficulty

associated with the available mechanisms for transferring Mission funds to the project. The Delivery Order mechanism is so cumbersome that it takes too much time to be feasible within the context of MotherCare's short remaining life span. The Field Support system, although preferred by the Missions because it is relatively expeditious, has limited usefulness because funds received through this mechanism are counted against the project's core ceiling and could therefore jeopardize MotherCare's ability to preserve enough of its core funding to finance its critical headquarters' activities.

It is clear that the Agency will need to agree upon a revised mechanism for the transfer of Mission funds to the project if MotherCare is to be extended and/or developed as a comprehensive "flagship" activity for *SO2*. The simplest revision, if it could be agreed upon, would be to increase MotherCare II's core ceiling so that the Field Support system can be used by Missions that wish to access MotherCare technical assistance.

Recommendation

31. USAID should explore ways of alleviating this procedural barrier so that Missions can avail themselves of MotherCare's services (e.g., streamlining the DO process or raising the core contract ceiling to allow for more field support transfers).

With respect to MotherCare II's LOE, the evaluation team has the strong impression that MotherCare's technical and support/administrative staff are all working overtime to maintain the project's current level of productivity. More staff are needed if MotherCare is to be able to extract the greatest benefit from investments already made. Perhaps the single greatest factor contributing to the increase in MotherCare's workload is the contractual mandate to provide short-term technical assistance to "as many developing countries as possible, in response to requests from Missions, Ministries of Health, PVOs, NGOs, and other donors." As MotherCare's work gains respect, these requests are more frequent, consequently, responding to them with existing staff detracts from MotherCare's ability to provide adequate support to its long-term emphasis country programs.

During our brief exposure to the project, the evaluation team judged that the greatest needs for additional MotherCare staff would be in the following priority work areas: field support in research methodology, IEC and evaluation; analysis of lessons learned; dissemination and advocacy; and sufficient technical and administrative staff to support the sharing of MotherCare experience in developing countries which request it.

Recommendation

32. The COTR should work with the project to encourage rapid recruitment to

fill all approved positions and with USAID to authorize additional staff as needed, including an IEC specialist and a nurse midwife for MotherCare's Indonesia office.